Title: Payment Adjustment for Health Care-Acquired Conditions
Section: 2702
State Mandate

Overview: Section 2702 of the Patient Protection and Affordable Care Act (ACA) requires state Medicaid programs to deny payments to providers for costs associated with treating Health Care-Acquired Conditions (HAC). The federal government will deny payments to states for any amounts expended by state Medicaid programs for medical assistance associated with HACs.

States are currently being surveyed to determine if there are procedures or practices in place to identify and deny payment. Once the survey results are completed, federal regulations will be issued and are to become effective July 1, 2011.

The law defines a HAC as a one that can be identified by a secondary diagnostic code that meets the following conditions: 1) high cost or high volume, or both; 2) results in the assignment of a case to a diagnosis-related group that has a higher payment; and 3) could reasonably have been prevented through application of evidence-based guidelines. HAC's include, but are not limited to, foreign object retained after surgery, air embolism, blood incompatibility, pressure ulcers, falls and trauma, catheter-associated urinary tract infections, and vascular catheter-associated infections.

Targeted Population: The targeted population includes health care providers and facilities whose treatment of a patient results in a Health Care-Acquired Condition, for which Medicaid is billed for the treatment of the HAC.

Fiscal Impact: At this time, it is not possible to determine the fiscal impact of this provision of the law. The identification of these occurrences is cumbersome and relatively subjective. The Division of Health Care Financing and Policy's (DHCFP) Surveillance and Utilization Review Unit (SUR) would likely be responsible for identifying a HAC and seeking recoupment of payment. The resources devoted to identifying and defending the recoupment of payment related to a HAC may not offset the recoupment amount.

Applicability to Nevada: DHCFP does not currently have in place any procedures or system edits to deny payment to providers who are treating a HAC. At this time, identification could be made through a post-payment review; meaning payment has already been made on both the primary and secondary diagnoses. The payment claim form includes a field to denote whether a condition was or was not present upon admission; however, this would assume that all

providers are correctly completing this field and would require a system edit to recognize which codes would be subject to denial.

Additionally, the current rate methodology used by Nevada Medicaid is a per diem methodology, instead of a diagnosis-related group (DRG) method of payment. This means that in order to discover a HAC, the DHCFP would have to identify claims where a secondary diagnosis was noted and a medical record review would need to be conducted. Alternatively, the State could rely on the provider to self-report and Division staff would need to determine how much of the cost of care should be recouped based on the fact that a HAC occurred. In a DRG payment structure, the cost for the HAC could be more readily identified and reported.

A possible option is to have the Recovery Audit Contractor (RAC) identify and recoup monies associated with a HAC. As the RAC employs physicians and utilizes data mining and claims review to identify incorrect payments to providers, the RAC may be better suited than the SUR unit to handle this responsibility.